Utah Commercial HMOs

A Guide for Consumers

Dear Consumer,

More Utahns than ever are enrolled in HMO plans. Selecting the right HMO plan for you and your family is an important decision. If your employer selects the HMO plan, actively participating in that decision is important to make the HMO plan work for you. This report provides the most reliable information currently available on the quality and overall performance of four of Utah's HMO plans.

This report summarizes how HMOs work, highlights how four HMOs compare in patient satisfaction ratings in overall quality and access to care, and how they performed in areas of access to routine care and prevention, such as breast cancer screening for cancer.

Though the data was audited for accuracy, this HMO report card has limitations. This is the first year of this type of publication and does not include information on other types of managed care plans. The number of plans and the type of information collected in the future will expand and improve with time.

I am pleased to present this report, *Utah Commercial HMOs: A Guide for Consumers*. This is the first in a series of reports to help consumers take responsibility for their health. The information in this report will help you work with your employer, your HMO plan and your doctor to make informed health care choices.

Sincerely

Executive Director
Utah Department of Health

Inside

Overview of HMOs

Traditionally, health care has been provided

by independent doctors and hospitals—you go to whatever health care provider you choose and the insurance company reimburses you the cost. A Health Maintenance Organization (HMO) is a type of managed care plan that offers members comprehensive health coverage through a network of selected physicians and hospitals in exchange for a prepaid premium.

HMOs differ, but they usually have these two elements in common: They contract with a network of doctors and hospitals; they monitor the performance of their doctors and hospitals and can influence the quality of care they provide.

Each HMO has its own network of doctors, hospitals and other health care providers with which it has negotiated fees. The plan then offers patients strong financial incentives (lower out-of-pocket costs) to encourage them to use the health care providers who are part of its network.

As part of their strategy to control costs, most HMOs require patients to see a primary-care physician (PCP), such as an internist or general practitioner, before consulting a specialist. The modern day equivalent of the traditional family doctor, the PCP is charged with knowing a patient's complete medical history, making the initial diagnosis and advising on further treatment.

For example, if someone complains of stomach pains, the primary care physician must first evaluate the patient and rule out basic problems before sending the patient to a specialist. Under a traditional (indemnity) plan, a patient could have more or less diagnosed him or herself, gone directly to a gastroenterologist, and been reimbursed for the visit by the insurance company.

On the plus side, HMOs generally have no deductibles, small co-payments, and no claims to file. That means, however, that the HMO provides no reimbursement (or a reduced amount) for non-emergency care with a doctor or hospital that is not a part of the plan's provider network.

A health plan should provide you with a

member handbook, a subscriber contract, a listing of doctors and hospitals under contract with the plan, and other information to help you select the right plan for you and your family. You should also ask the plan the following type of questions:

1. Is the health plan accredited by an outside agency, such as the National Committee for Quality Assurance (NCQA)?
2. Is my regular doctor a part of the health plan's network? Will I be able to see the same primary care doctor all of the time?
3. If I am under the care of a specialist, is he or she part of the plan's network? If I need services from a specialist not affiliated with my health plan, will the health plan make exceptions?
4. What services does the plan cover? What preventive services does the plan offer (e.g. physical exams, immunizations)?
5. What are the plan's standards for how close members must be to their doctors and hospitals?
6. After-hours care—how do I obtain it and where?
7. How do I receive care if I am out of town or in another state?
8. What are the plan's policies relating to pre-existing conditions?
9. How are the complaints or grievances handled?
10. What are the results of patient and consumer satisfaction surveys?
11. What is the voluntary disenrollment rate? How does that compare with state or national rates?
12. Does the plan require prior authorization? What is the procedure?
13. Does the plan offer translation services if needed ?
14. What are my premium costs? Co-payments? Deductibles?
15. I am covered by a second insurance policy, will the plan bill the second insurance policy?

Sources of Information

This report is a collaborative effort

between HMOs, the Utah Department of Health, and the Utah Health Data Committee. It is intended to contribute to consumer awareness and to assist health plans in their efforts to improve service and care. The information presented in this report comes from two sources:

1. **Utah 1996 HMO Enrollee Satisfaction Survey.** From June to October 1996, over 2,000 HMO members were contacted by telephone and asked in-depth questions about how satisfied they were with their HMOs. The survey was administered by DataStat, Inc., an independent survey research firm. HMO plans that participated in the 1996 survey included:
   - Blue Cross/Blue Shield of Utah (HealthWise)
   - FHP/PacifiCare of Utah* (purchased by PacifiCare of Utah, Feb. 1997)
   - Intermountain Health Care (IHC Care)
   - United HealthCare of Utah

2. **HMO HEDIS** Performance Measures.** Also included in this report is a set of HMO performance measures called HEDIS. HEDIS measures were developed by the National Committee for Quality Assurance (NCQA) to ensure that information is available to reliably compare the performance of managed health care plans. NCQA conducted an audit to verify the accuracy of the HEDIS data presented in this report. HMO plans that participated in this HEDIS project included:
   - Blue Cross/Blue Shield of Utah (HealthWise)
   - CIGNA HealthCare of Utah
   - Intermountain Health Care (IHC Care)
   - United HealthCare of Utah

Utah Commercial HMOs: A Guide for Consumers is published by the Office of Health Data Analysis, Utah Department of Health. For additional copies, please call (801)538-7048. This report is also available on the Office's internet site at http://hlunix.hl.state.ut.us/hda/.

*FHP/PacifiCare withdrew from public reporting of HEDIS measures.

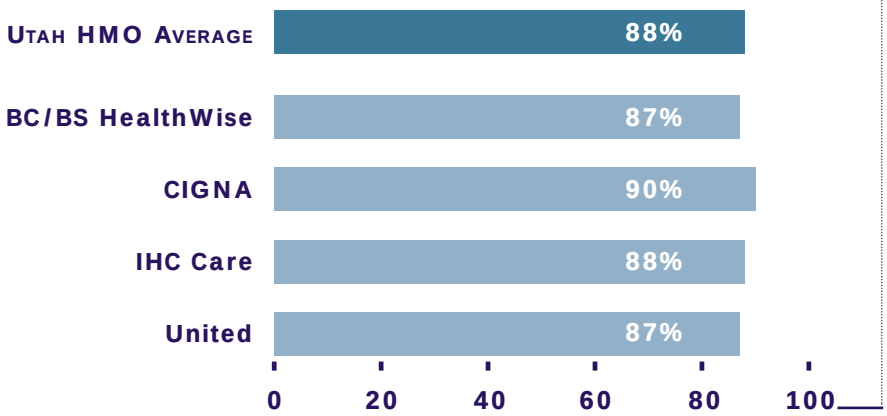
** HEDIS (Health Plan Employer Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA).

Readers of this booklet should be aware

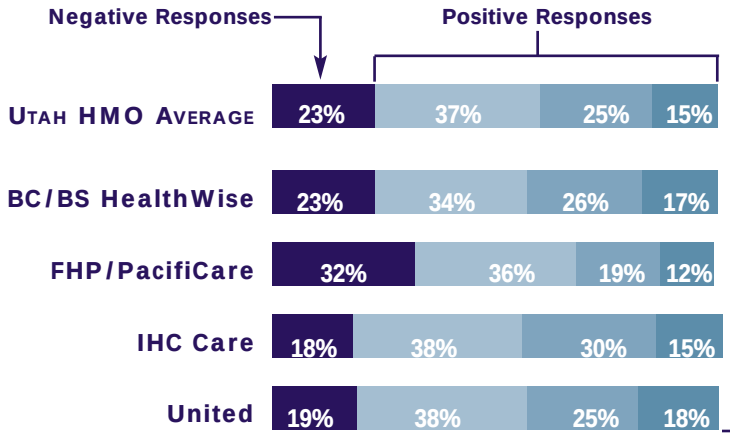
that the data presented here has limitations. It should be thoughtfully considered along with information from other sources, including your doctor, family, and friends. In the future, when more information is available, it would be useful to see if your HMO changes its performance over time.

How to Read Bar Graphs

Bar graphs like the one shown below display the percentage of HMO members corresponding to each HMO performance measure. The bar on the top of each chart represents the average for all participating HMOs.



Stacked bar graphs show the satisfaction survey results. The bar at the top shows the Utah HMO average. The bars below that illustrate how each participating HMO rated. Shown on the right hand side in shades of blue is the percentage of HMO members who gave the plan a positive rating of "good," "very good," or "excellent" on the survey question. The dark purple bar shows the percentage who gave the plan a negative rating of "poor" or "fair."



To make an informed decision, consumers

need to have information that is comparable and audited. Comparable means the data has been collected and calculated the same way by all the plans involved and audited indicates that an outside organization has checked that all the data is accurate. Currently, there are four non-profit organizations working to ensure that this type of information is available. HMOs voluntarily request and pay for the accreditation process.

- The **National Committee for Quality Assurance** (NCQA) is a Washington-based non-profit organization that accredits managed care plans based on fairly stringent quality criteria. Those that meet NCQA's standards are accredited. Over 330 plans nationwide have been reviewed by NCQA. (The data on pages 10–11 was audited by NCQA.)
- The **American Accreditation HealthCare Commission** (AAHCC), formerly known as the Utilization Review Accreditation Commission (URAC), was founded in 1990 to look at how a plan determines whether a medical procedure is necessary. In 1996 it expanded its accreditation process to include other areas of quality of care. Currently, 177 companies are accredited under AAHCC's Health Utilization Management program.
- The **Joint Commission on the Accreditation of Healthcare Organizations** (JCAHO) was founded in 1951 to improve the quality of care provided to the public by reviewing and accrediting health care organizations, including hospitals and home health agencies. In 1994, JCAHO began a program to accredit managed care companies. To date, JCAHO has reviewed 25 managed care networks nationwide.
- The **Foundation for Accountability** (FACCT) is a coalition of employers and consumer organizations dedicated to the development of consumer-focused quality measures and tools to assist consumers in using this information. FACCT does not accredit managed care plans.

The chart below offers some basic

information about each HMO. For additional information, call the individual health plan (see page 14 for a list of contact numbers) or visit our home page (http://hlunix.hl.state.ut.us/hda). When comparing HMOs, keep in mind that each has its own network of providers and policies regarding how and when you may see them.

HMO	HMO Enrollment[1]	Company Enrollment[1]	NCQA Accreditation	Areas Served	HMO's Provider Network		
					Number of PCPs	Number of Specialists	Number of Hospitals
BC/BS HealthWise	31,199	521,000	No Review	Wasatch Front	600	1,300	20
CIGNA	33,800	43,000	Full	Wasatch Front	450	1,000	15
FHP/PacifiCare	149,513	194,231	One Year	Statewide	598	1,078	26
IHC Care	162,026	342,425	Full	Statewide	893	1,291	24
United	109,646	109,646	No Review	Wasatch Front	814	913	20

NCQA Accreditation: Full indicates the plan has excellent quality improvement programs, meets NCQA's rigorous standards and is accredited for three years; **One Year** indicates the plan has well established quality improvement programs, meets most NCQA standards, and will be reviewed again in a year to determine if it can move up to full accreditation; **No Review** indicates the HMO has not been reviewed (none of the plans listed have been reviewed by any of the other organizations listed on page 6).
Company Enrollment: The total number of enrollees in all of the company's products (i.e. HMO, PPO, fee-for-service, etc.)
PCPs: Primary Care Physicians
[1] = As of December 31, 1996
NOTE: Information on this page – except for accreditation status – has been self-reported by the health plans.

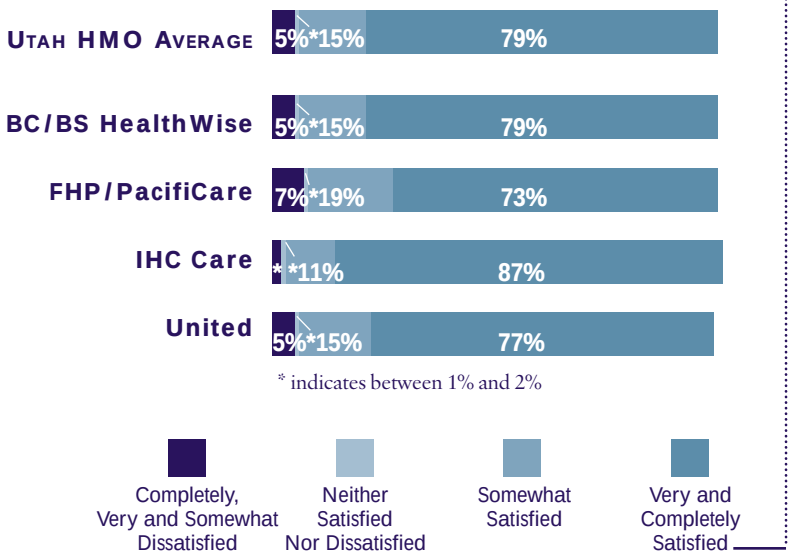
When you are enrolled in an HMO, you

receive all of your medical services through that plan. That is why an HMO should make using its services an easy, comfortable experience. The charts on these two pages tell you how plan members felt about their HMO's service.

Overall Plan Rating

Before getting detailed information about what aspects of their plan enrollees were pleased and displeased with, it is important to understand how satisfied they were with the plan in general. This graph illustrates how HMO members rated their plan on:

All things considered, how satisfied were you with your health plan?

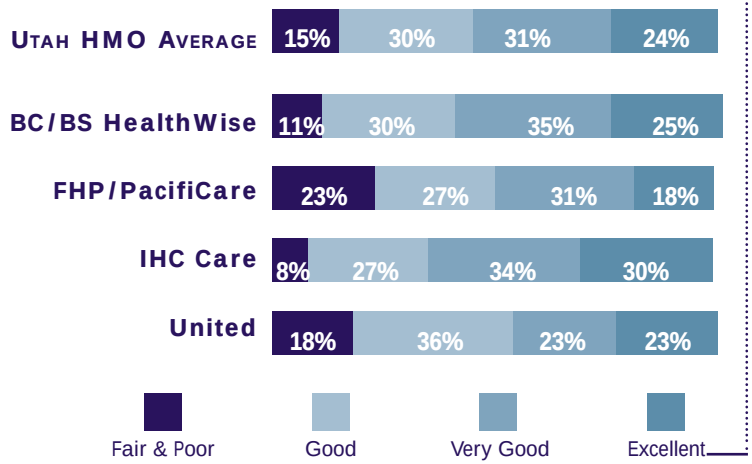


* indicates between 1% and 2%

Ease of Finding a Personal Doctor

Choosing a personal doctor, or primary care physician (PCP), is one of the most important decisions you will make after choosing a health plan. This is because he or she will probably coordinate your care. This graph illustrates how HMO members rated their plan on:

How easy was it for you to choose a personal physician?

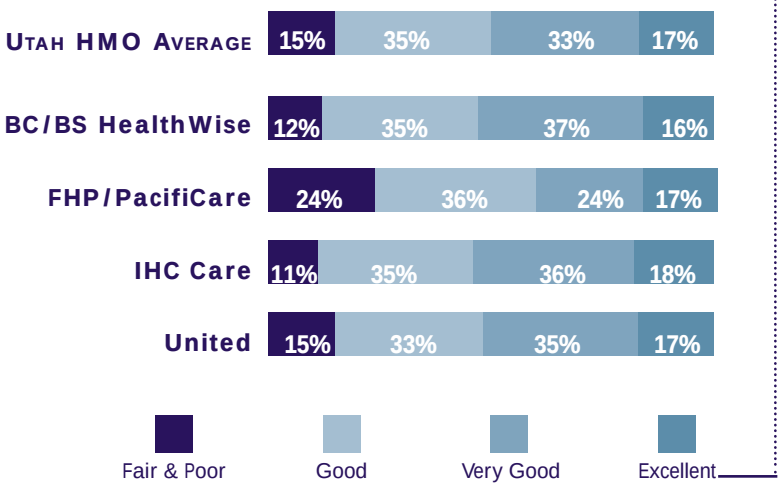


NOTES: Percentages may not add up to 100% due to rounding. Enrollees with no visits to a health care provider or hospital stay during the past 12 months were excluded from the calculation.

HMO Internal Communication

Managed care plans are made up of networks of health professionals and facilities, that must work together to coordinate your care. That means that how well they communicate with one another can help determine how good the care you receive is. This graph illustrates how HMO members rated their plan on:

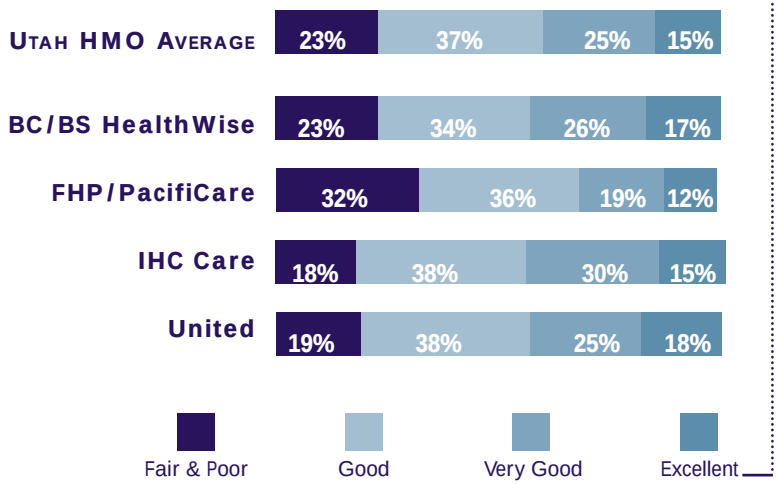
How well did people and different departments in your health plan communicate in order to coordinate care and services?



Access to Services After Hours

Unfortunately, no one can plan their medical emergencies to occur on a convenient 9 to 5 schedule. HMO members must have access to medical services 24-hours a day. This graph illustrates how HMO members rated their plan on:

How accessible were the plan's services and medical care to you during evenings, nights and weekends?



NOTES: Percentages may not add up to 100% due to rounding. Enrollees with no visits to a health care provider or hospital stay during the past 12 months were excluded from the calculation.

Access to Routine Care

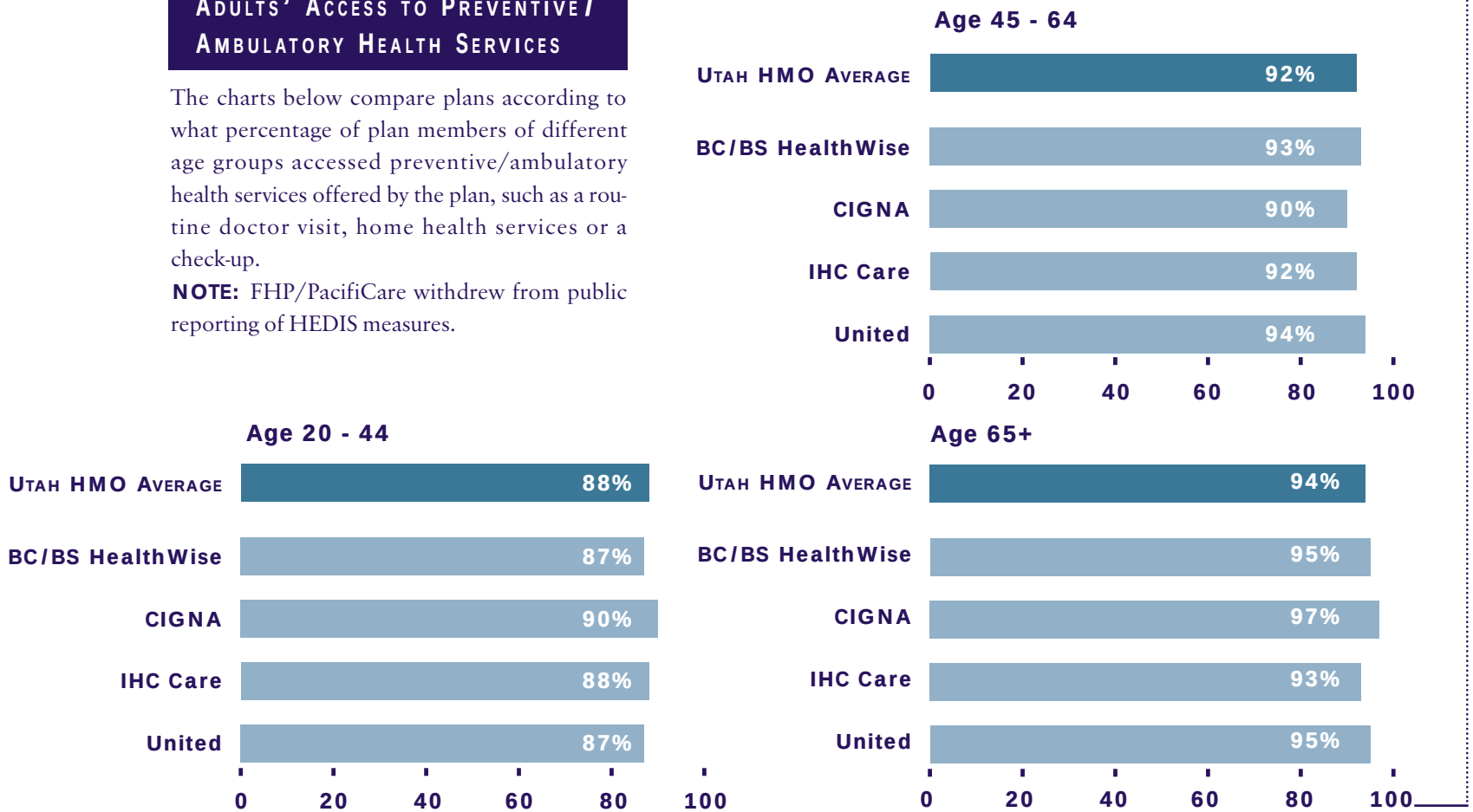
It is very important that an HMO provide

members with timely and convenient access to appropriate medical care. The bar charts on this page allow you to compare plans according to what percentage of their members accessed routine health care services.

Adults' Access to Preventive/ Ambulatory Health Services

The charts below compare plans according to what percentage of plan members of different age groups accessed preventive/ambulatory health services offered by the plan, such as a routine doctor visit, home health services or a check-up.

NOTE: FHP/PacifiCare withdrew from public reporting of HEDIS measures.

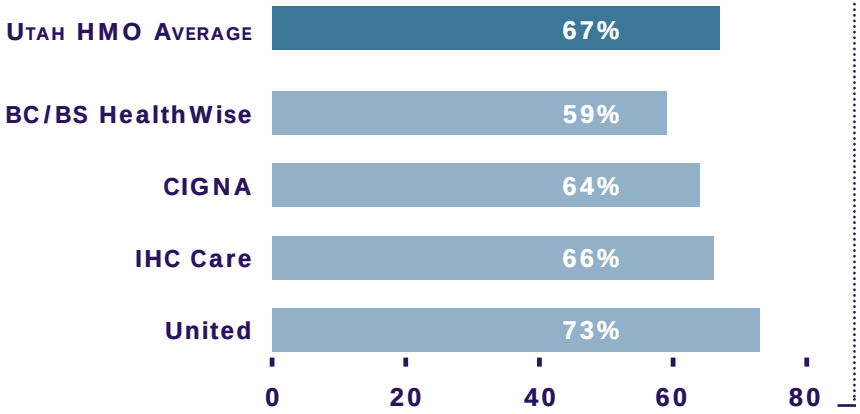


At the top of everyone's mind when

comparing health plans is how well the plan treats the medical problems of its members. One way to determine this is to see how well the plan incorporates widely accepted preventive measures (such as childhood immunizations), recommended screenings (like mammography) and how it treats members with chronic diseases (such as asthmatics and diabetics).

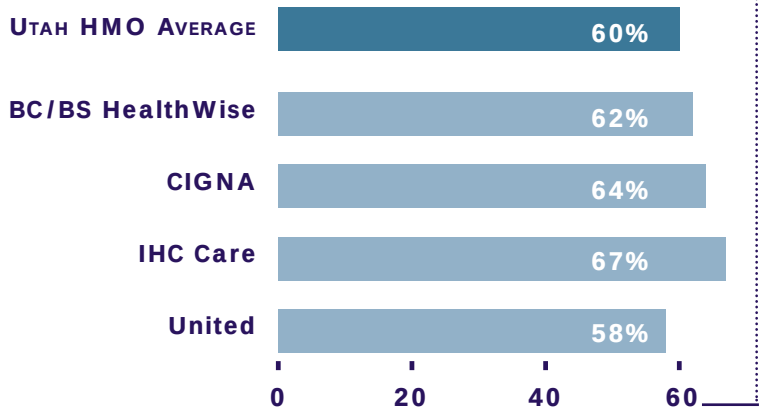
BREAST CANCER SCREENING

Breast cancer is the most common type of cancer among American women. Fortunately, breast cancer deaths can be significantly reduced with early treatment. Mammograms are the most effective method for detecting small tumors. This bar chart shows what percentage of the plan's female members between the ages of 52 and 64 got mammograms in the past two years.



CERVICAL CANCER SCREENING

Cervical cancer can be detected in its early stages by regular screening using a Pap smear test, which has been credited with reducing the number of deaths from cervical cancer by as much as 75 percent. The chart below shows what percentage of women between the ages of 21 and 64 had one or more Pap smears during the past three years.



NOTE: FHP/PacifiCare withdrew from public reporting of HEDIS measures.

Childhood Immunization Schedule

Vaccines have virtually eliminated many

childhood diseases like whooping cough, hepatitis and meningitis. Since preschool children are the most susceptible to these dangerous diseases, children should receive most of their vaccinations during their first two years of life, starting at birth. The American Academy of Pediatrics (AAP), recommends your child get the following vaccinations to stay healthy. Make sure your health plan provides your child with all the necessary vaccines.

- **DTP.** Protects against diphtheria, tetanus (lockjaw) and pertussis (whooping cough).
- **Polio.** To protect against polio, your child may be given either the Oral Polio Virus (OPV) or the Inactivated Polio Vaccine (IPV).
- **MMR.** Protects against measles, mumps and rubella (German measles).
- **HBV.** Protects against hepatitis B, which causes liver disease.
- **Hib.** Protects against Haemophilus influenza type b, a major cause of spinal meningitis.
- **Td.** Booster to protect against tetanus and diphtheria
- **VZV.** Protects against the Chicken Pox.

Age	DTP[1]	Polio[2]	MMR	HBV	Hib[3]	Td	VZV
Birth				✓			
1-2 Months				✓			
2 Months	✓	✓			✓[4]		
4 Months	✓	✓			✓[4]		
6 Months	✓				✓[4]		
6 - 18 Months		✓		✓			
12 - 15 Months			✓		✓[4]		✓[5]
15 - 18 Months	✓[6]						
4 - 6 Years	✓[6]	✓					
11 - 12 Years			✓[7]	✓[8]			
14 - 16 Years				✓[8]			
Every 10 Years After						✓	

1 The HbOC-DTP combination vaccine may be substituted for separate Hib and DTP vaccines.
2 Children in close contact with immunosuppressed individuals should receive Inactivated Polio Vaccine.
3 Infants of mothers who tested seropositive for hepatitis B surface antigen should receive hepatitis B immune globulin at or shortly after the first dose. These infants also will require a second hepatitis B vaccine dose at 1 month and a third at 6 months of age.
4 Depends on which Hib vaccine was given previously.
5 APP recommends that all children, adolescents and young adults who have not already had the chicken pox nor the VZV vaccine, be inoculated.
6 For the fourth and fifth dose, the acellular pertussis (DTaP) vaccine may be substituted for the DTP.
7 Except where public health authorities require otherwise.
8 Where resources permit, the HBV series of three immunizations should be given to previously unimmunized preadolescents or adolescents.

This brochure provides information

about how satisfied HMO members were with their plan, as well as some HEDIS performance measures. You are encouraged to seek additional information about the plan from as many sources as possible, including your doctor, family and friends. This worksheet will help you organize the information you receive about local HMOs.

HMO	Which HMO providers are available where you live and work?	Which HMOs include your preferred doctor or health care provider?	Which HMOs scored well based on information in this booklet*		
			HMO Service	Access to Routine Care	Helping to Keep People Healthy
BC/BS HealthWise					
CIGNA					
FHP/PacifiCare					
IHC Care					
United					
Other					
Other					

* Review the information from each question of this booklet. For each section check the HMO that you think performed the best. If you are comparing a plan not included in this booklet, ask the plan for more information or contact NCQA (888-275-7585) to find out if they have reviewed that plan.

Getting More Information

If you have concerns about your treatment

or feel you have been denied health services, you may call your HMO. The HMO will explain how to file a grievance. You must go through all steps of the HMO's grievance process. If you disagree with the HMO's final decision, you can file a complaint with the Utah Department of Insurance by calling 800-439-3805or 801-538-3805.

Plans	Telephone Numbers
BC/BS HealthWise	481-6176 or 800-662-6516
CIGNA	800-245-2471
FHP/PacifiCare	800-377-4161 ▶ For health information call their 24-hour hotline: 888-747-8088
IHC Care	442-5038 or 800-538-5038
United	942-6200 or 800-824-9313 ▶ For urgent care call OPTUM, their 24-hour hotline: 800-642-9564

Additional resources provided by the Utah Department of Health

- **Utah Office of Health Data Analysis** offers more information about the HMO patient satisfaction survey and "report card" results. Call 801-538-7048 or visit their web site (http://hlunix.hl.state.ut.us/hda/).
- **Utah Bureau of Health Facility Licensure** offers information about compliance with licensing standards. Call 801-538-6152.
- **Check Your Health Hotline** provides health-related information and referrals. Call toll-free at 888-222-2542. The hotline is open Monday through Friday, 8am to 5pm.

Your Rights and Responsibilities

Know Your Rights

Know your rights as a patient. You have the right to:

- See your primary care doctor.
- Urgent or after hours care for medically necessary conditions.
- Make a complaint or appeal a decision made by your HMO.
- Receive specialty care that is medically necessary.
- See your medical records.
- Be informed about medical services.
- Make an informed decision about proposed medical services.
- Privacy and confidentiality about your medical condition.

Know Your Responsibilities

Know the rules of your HMO plan before you use medical services. You have a responsibility to:

- Select a regular medical doctor.
- Schedule appointments and keep them, or call to cancel.
- Read materials given to you and ask questions about anything you do not understand.
- Before seeing other medical doctors, make sure that you follow the rules of your HMO about referral to other providers. If you see a specialist without a referral, you may have to pay the bill.
- Use hospital emergency rooms, after hours, and urgent care facilities for emergencies or urgent care only. If the visit is a non-emergency, you may have to pay the bill.
- File a grievance according to the health plan's procedures if payment is denied.
- Maintain your health, by eating right, exercising, getting regular check-ups and following your doctor's instructions.

Acknowledgments

This report was prepared by the Office of Health Data Analysis, Utah Department of Health, under the direction of the Utah Health Data Committee and the HMO Advisory Subcommittees as part of Utah HMO Performance Measurement Project.

To receive additional copies of this report, you can contact us at: Office of Health Data Analysis, 288 N. 1460 W., Box 144004, Salt Lake City, UT 84114-4004; 801-538-7048 (phone); 801-538-9916 (fax); dlove@doh.state.ut.us (e-mail). This report is also available on the World Wide Web at http://hlunix.hl.state.ut.us/hda/

Editorial and design assistance was provided by Health Pages and Ryley Foog.

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The Health Data Committee would like to acknowledge the assistance of the following organizations in various stages of the planning and implementation of the HMO Performance Measurement Project and the preparation of this report.

Blue Cross/Blue Shield of Utah, represented by Tom Carl and Ann Nevers

CIGNA Health care of Utah, represented by Lynette Hansen

FHP/PacifiCare of Utah, represented by Connie Miller, James Moore and Mitch Carter

Intergoup of Utah, represented by Debby Moore

Intermountain Health Care of Utah, represented by Michael Mundorff, Leon Lamoreaux, Gene Smith and Tom Beggs

United Health Care of Utah, represented by Betty Streed and Gail Rapp

National Committee for Quality Assurance (NCQA), represented by Karen Onstad and Jessica Briefer French